

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-003728

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **715**

FILED JAN 31 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN University City	
c. FULL NAME OF (If NOT in hospital, give location) Jewish Hospital		d. STREET ADDRESS (If outside, give location) 516 Mapleview Drive	
3. NAME OF DECEASED (Type or print) EMIL KOPLIN		4. DATE OF DEATH Month January Day 21 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (last birthday) Ab65		10. IF UNDER 1 YEAR Months 6 Days 5	
11. IF UNDER 24 HR Hours 6 Min. 5		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jacob Koplin		13b. MOTHER'S MAIDEN NAME Ida Cutler	
14. NAME OF HUSBAND OR WIFE Mrs. A. Copilevitz-516 Mapleview		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of both Lower Extremities DUE TO (b) Arteriosclerosis Obliterans DUE TO (c) 450.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour 2:30 a.m. 2:30 p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Dec. 20, 1962 to Jan. 21, 1963 and last saw her/him alive on Jan. 20, 1963 Death occurred at 2:30 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Alvin S. Wenzel, M.D.		22b. ADDRESS 8112 Delmar	
22c. DATE SIGNED 1/22/63		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 1/23/63	
23c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.		23d. LOCATION (City, town, or county) St. Louis County, Mo.	
24. FUNERAL DIRECTOR Herman Rindskopf, Inc.		ADDRESS 5216 Delmar	
25. DATE RECD. BY LOCAL REG. JAN 23 1963		26. REGISTRAR'S SIGNATURE Dean Smith, M.D.	

FORM 1-1960 (7-2-1-7)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John Ketter
Licensed Embalmer No. 3880

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.